

## **AMCHP Annual Conference, 2010**

### **Moving Ahead Together:**

#### **Celebrating the Legacy, Shaping the Future of Maternal and Child Health**

#### **The Nuts and Bolts of Building Community-Based Service Systems for CYSHCN**

March 6-10, 2010

UNKNOWN SPEAKER: So now we're onto step six, measuring your outcomes. And as what was mentioned when you were looking at community assessments that's a measurement effort in itself. We're going to take a look at in terms of your overall big picture measurement as you've developed this new system, how do you know its working? You need to tie it to your vision and mission going back to what's important there. Then in terms of the outcomes there are different levels. Well there is measuring what you're doing, you know your process outcomes and Colorado has some good examples with that and you've got to measure your changes in terms of what are you changing for families for example for the communities and so there's some short term outcomes and some long term outcomes and then the importance of looking at costs. You know when you go back to things like saying a business case model have you really been able to show that? And then using that data could continually drive how you go back to bringing in new stakeholders, revising the plan, etc. And so I'm going to turn it now to Colorado.

UNKNOWN SPEAKER: So back to the simplification where we decided...when we decided to frame everything under a medical home system...because when you look at

the seven components of medical home continuous, comprehensive, culturally competent, family centered, accessible, all of those. That really matches exactly what we're trying to do. So as the director of the medical initiative for Colorado one of the sayings, me and my bumper sticker sayings is that what I wanted to try to set the vision is that we will be a medical home state one medical home community at a time. And that helped us frame that and so with that we're using our care coordination and I do have copies in the back and this care coordination intake form if you will for families and the six questions, very simple are those from the national health survey so that we are not reinventing new questions. That's a really key point that we're looking at and also our medical home initiative again is based primarily on...it's one of the things I say is medical home is not a noun, it's a verb. And the way we provide a medical home approach at the community level is what systems change will look like. And so the medical home community approach is what drives a lot of this and so that's what we're measuring. We are measuring not how many doctors and not how many pediatricians consider themselves a medical home. We are measuring coalition building, levels of care coordination. It's a lot harder to do. Our evaluators out of the university have worked really long and hard to figure out how we were measuring coalition building and community development but it's worth it. It's part of the measurement that we are dedicated to because of this community approach. So these are available in the back and again it's a draft form for us as well and we're happy to share whatever we need to with you.

UNKNOWN SPEAKER: So all of our surveys that we've pulled together, the community surveys are going to be...it's going to be complimented by the Title V needs assessment process that we're going through. For this needs assessment process we...sent out two surveys, one a broad based Utah stakeholders survey and one a family CSHCN survey and all of those are going to be zip code specific so we'll be able to overlie the results of those and add them to our results and sort of strengthen our understanding of that area...of those community areas. Short and sweet.

UNKNOWN SPEAKER: Sure, actually on step six, Maine is not there yet. We're still in the planning phase of how to do evaluation and how to measure all the things that we're doing. I would just like to say that we have involved our families and our youth in the Title V five year needs assessment and actually Anna can comment on that. She's the one that's going to talk to you about the evaluation and where she would like to see us go.

ANNA CYR: What I have been...what I would like to see happen as a family person is to number one many families were...I don't know how many but many families were moved off the program gradually over time and you know they were worked with and sort of care coordinated before they were off the program but I think that there should be a follow up with those families and find out where they are today, how they're doing, if they're having any problems. The other thing is as this Partners in Care Coordination program starts up I think its going to be very important to A. keep consistent data on what types of calls you're getting, what types of referrals you're making and then follow

up calls with the families to find out if really, if where they were sent is helpful and that feeling of connection with the families so that they know that you weren't just a one shot deal that you were...okay here's your help don't bother us again. That you are reaching out to them. We don't know if that's staff-wise possible but we're going to make an effort to do that.

DIANE BEHL: Some thoughts. Here are just some other ideas. Again something that we've been promoting through Champions Inc. in terms of how can you use data that you maybe have to help you get a handle on the needs of families, what's working for them in your communities. The national survey of CSHCN that Eileen mentioned they use those survey questions and embedded them in some of their community level forms. And they'll give you information and what were the unmet needs of families who helped coordinate care for those families and their reasons for difficulties such as too much paperwork, transportation, all those kinds of things are in those cool questions and one of the things that's in your folder is a tool guide that Champions developed called Drilling Down through Outcome 5 that can give you a sense of what the issues are for your state. You may be able to break it down to an urban, rural kind of mix, but it gives you the opportunity of saying can we use those questions and apply them within all of our communities? Same with the national survey of children's health, taking a look at your cap state. Does anyone use their cap state in their state? Do you know what it is? Anyone want to know what it is. Okay I'm trying to remember the C...assessment of health plans surveys. Consumer...thank you Nora, all right. It's an example of data that often your Medicaid program has in your state that gives again data on often they have

now been incorporating the CSHCN screener within that and so it's again more data that you can use from your state partners to say how can we understand the issues families are facing? Prans data, your behavior, risk factor, surveillance survey data all those can be really useful in terms of looking at what information you have now and how can you potentially use it to better understand what's in your communities.

We're out of time and I apologize that we don't have time for this last small group effort. Again your questions are there and so what I'm hoping is as you're running this through your head, how it applies to you look through those questions. Okay. If you're interested oh...